ARC 0585C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services adopts amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

The Health Care and Education Reconciliation Act of 2010 (HCERA), Section 1202 (Public Law 111-152) (42 U.S.C. § 1396a(a)(13)(C)), requires that state Medicaid programs increase payments to primary care specialties specified under Section 1202 of the Act. In particular, HCERA identifies the following specialty designations: "family medicine," "general internal medicine," and "pediatric medicine." The payment requirement specifies that reimbursement must be "… at a rate not less than 100 percent of the payment under Part B of title XVIII [Medicare]." Section 1202 of the Act also specifies the types of services that fall under this requirement. Those services include: (1) services designated as "evaluation and management" under the healthcare common procedure coding system (HCPCS), as of December 31, 2009 (and subsequently modified), which are current procedural terminology (CPT) codes in the ("evaluation and management") range 99201-99499; and (2) services related to immunization administration, billed with current CPT codes 90460, 90461, 90471, 90472, 90473 and 90474.

Section 1202 of the Act also requires that these same changes be made for Medicaid managed care plans. In that regard, such changes are being effectuated by contract amendments with the current (and only) medical managed care plan administered by Meridian Health Plan. Beyond Meridian, there are no other managed care plans that would be affected. Because these changes are being addressed via contract amendment, there are no changes being made to managed care rules under 441—Chapter 88.

Section 1202 of the Act specifies that these increased payments are only to be in effect for calendar years 2013 and 2014.

Final regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) allow for two criteria to identify the applicable practitioners meeting the requirements of Section 1202 of the Act:

1. The first method is board certification by the national specialty boards applicable to each specified group (i.e., the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA)).
2. The second method is claims history of at least 60 percent of a given practitioner's Medicaid claims attributable to the primary care services (i.e., procedure codes) specified under Section 1202 of the Act.

Providers must certify that they meet one or both of these criteria.

The Council on Human Services adopted these amendments on January 9, 2013.

Pursuant to Iowa Code section 17A.4(3), the Department finds that notice and public participation are unnecessary because they are impracticable. Recently CMS finalized rules pursuant to Section 1202 of the Act which specify that these changes must be implemented by January 1, 2013. However, because CMS did not issue final rules until November 6, 2012, combined with uncertainty on how these changes would need to be implemented, the Department was unable to move forward until this time.

In addition, failure to waive notice would be contrary to the public interest. The increased payments for primary care services and providers as specified in Section 1202 of the Act will expand access to these services for the public.

Pursuant to Iowa Code section 17A.5(2)"b"(2), the Department further finds that the normal effective date of these amendments, 35 days after publication, should be waived and the amendments made effective January 9, 2013. The implementation period can be waived since the rule making confers a benefit on the public. The increased payments to primary care providers will confer a benefit on the public, as well as for qualifying Medicaid providers, which will in turn increase access to the specified primary care services.

These amendments are also published herein under Notice of Intended Action as **ARC 0584C** to allow for public comment.

These amendments do not provide for waiver in specified situations because the amendments confer a benefit of increased payment to identified primary care providers specified under Section 1202 of the Act. Requests for waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, there is a potential for positive impact on private sector jobs. According to CMS, "the overall benefit of this rule is the expected increase in provider participation [in Medicaid] by primary care physicians resulting in better access to primary and preventive health services by Medicaid beneficiaries." 77 Fed. Reg. 66670 (Nov. 6, 2012). On that basis, there will be a positive impact on private sector jobs and employment opportunities for primary care physicians and associated personnel.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments became effective January 9, 2013.

The following amendments are adopted.

ITEM 1. Amend subrule **79.1(2)**, provider category "Physicians (doctors of medicine or osteopathy)," as follows:

Provider category	Basis of reimbursement	Upper limit
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/12 less 2%.
Qualified primary care services furnished in 2013 or 2014	See 79.1(7)*"c"*	Rate provided by 79.1(7)*"c"*

ITEM 2. Adopt the following **new** paragraph **79.1(7)"c"**:

c. Payment for primary care services furnished in 2013 or 2014. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar years 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to this paragraph (79.1(7)*"c"*).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)*"c"*) include:

1. Evaluation and Management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)*"c"*), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)*"c"*) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)*"c"*), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service.

(4) Primary care services eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(A)(1).

(5) Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the vaccines for children program in calendar years 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the vaccines for children program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

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